

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D35

PROVIDER –
Meridian Hospitals Corporation – Group
Appeal

Provider Nos. See Appendix I

vs.

INTERMEDIARY – Blue Cross Blue
Shield Association/ Riverbend
Government Benefits Administrator
(formerly Blue Cross Blue Shield of New
Jersey/ Horizon Blue Cross Blue Shield of
New Jersey)

DATE OF HEARING-
May 21-22, 2002

Cost Reporting Period Ended
December 31, 1996

CASE NO. 99-2241G

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ISSUE:

Were the Intermediary's adjustments disallowing the Providers' claimed losses on disposal of assets due to a change of ownership proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Meridian Hospitals Corporation ("Meridian") is a New Jersey, not-for-profit entity which was formed through the consolidation of three New Jersey, not-for-profit hospitals: Jersey Shore Medical Center ("Jersey Shore"), Riverview Medical Center ("Riverview"), and Medical Center of Ocean County ("MCOC"), collectively referred to as the "Predecessor Hospitals." The Predecessor Hospitals are the "Providers" which comprise the Meridian Hospitals Corporation-Group Appeal for PRRB Case No. 99-2241G. Following the effective date of the consolidation, January 1, 1997, each Provider submitted its terminating Medicare cost report for the fiscal year ended ("FYE") December 31, 1996 to Blue Cross Blue Shield of New Jersey which later became Horizon Blue Cross Blue Shield of New Jersey ("Intermediary").¹ Relying on the regulatory provisions of 42 C.F.R. § 413.134 *et seq.*, each cost report included a depreciation adjustment which recognized a loss on disposal of assets resulting from the consolidation.

Upon audit of the cost reports and the loss calculations of the Providers, the Intermediary issued Notices of Program Reimbursement denying the claimed losses citing the related party rules at 42 C.F.R. § 413.17 *et seq.* The Providers appealed the Intermediary's determinations to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The estimated amount of Medicare reimbursement in controversy for the group appeal is approximately \$34,000,000.² The Providers were represented by Michael J. Kalison, Esquire, and Todd Schaper, Esquire, of Kalison, McBride, Jackson & Murphy, P.A. The Intermediary was represented by Eileen Bradley, Esquire, of the Blue Cross Blue Shield Association.

Background Concerning the Consolidation of the Providers:

In March of 1996, the Predecessor Hospitals entered into a Letter of Intent ("LOI") to explore the creation of an integrated system of healthcare delivery.³ The LOI required the parties to diligently review each other's information and execute a Definitive Agreement within 90 days. A Definitive Agreement was executed on June 26, 1996, wherein it was agreed that the Predecessor Hospitals would consolidate into Central

¹ In the summer of 2000, Riverbend Government Benefits Administrator assumed Horizon Blue Cross Blue Shield of New Jersey's fiscal intermediary duties as a subcontractor of the Blue Cross Blue Shield Association.

² See Intermediary's Position Paper at p.3.

³ See Providers' Exhibit P-1.

Jersey Hospital, Inc. (“CJH”).⁴ The separate existence of the Predecessor Hospitals would cease at the moment of consolidation to be effective January 1, 1997. Pursuant to the Plan of Consolidation that was incorporated into the Certificate of Consolidation, CJH changed its name to Meridian Medical Center, Inc. on January 1, 1997.⁵ Thereafter, Meridian Medical Center Inc. changed its name to Meridian Hospitals Corporation.

In accordance with the New Jersey Health Care Facilities Planning Act, the Predecessor Hospitals applied for a Certificate of Need (“CON”) with the State of New Jersey, Department of Health and Senior Services (“DHSS”) on July 1, 1996. The Commissioner of DHSS approved the CON application in a letter dated December 20, 1996 stating that the proposed consolidation “satisfied the statutory and regulatory criteria . . . for the approval of an application for a [CON] for the transfer of ownership of an acute care hospital.”⁶ As a result of the consolidation, Meridian was vested with the real and personal property of the Predecessor Hospitals and assumed all of the obligations and liabilities of each of the corporations so consolidated.

Relevant Medicare Statutory and Regulatory Background:

Pursuant to the statutory provisions of 42 U.S.C § 1395x(v)(1)(A), the Medicare program reimburses providers for covered medical services rendered to Medicare beneficiaries based on the reasonable costs actually incurred in the efficient delivery of needed health services. The Centers for Medicare and Medicaid Services (“CMS”) is the operating component of the Department of Health and Human Services (“DHHS”) charged with the administration of the Medicare program.⁷ The Secretary of DHHS is authorized to promulgate regulations prescribing the methods to determine reasonable costs and the items to be included.

Under the regulatory provisions of 42 C.F.R. § 413.134 *et seq.*, a provider of medical services is entitled to claim the reasonable costs associated with the depreciation of buildings and equipment used to provide health care to Medicare patients. In determining annual depreciation, the historical cost of an asset is prorated over its estimated useful life in accordance with one of several authorized methods. Providers are then reimbursed on an annual basis for a percentage of the yearly depreciation equal to the percentage of the assets used for the care of Medicare patients.

Since the calculated annual depreciation is only an estimate, the regulation at 42 C.F.R.

⁴ See Providers’ Exhibit P-2.

⁵ See Providers’ Exhibit P-3.

⁶ See Providers’ Exhibit P-4.

⁷ CMS was known as the Health Care Financing Administration (“HCFA”) at the time denial actions were taken against the Providers. This decision will refer to the name of the agency as CMS unless otherwise required by the context. The Providers also use the term “Agency” to collectively refer to the administrative components of the Medicare program.

§ 413.134(f) provides for the determination of a depreciation adjustment where a provider incurs a gain or loss on the disposition of a depreciable asset. This regulation deals with the disposition of assets through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft or other casualty. If an asset is disposed of for less than the depreciated basis calculated under Medicare (net book value), then a “loss” has occurred because the consideration received for the asset is less than the estimated remaining value. In the event of a loss, the Medicare program assumes that more depreciation has occurred than was originally estimated, and the provider receives additional reimbursement in the form of a depreciation adjustment. Conversely, if a provider receives consideration for a disposed asset which is greater than the depreciated basis, then a “gain” has occurred, and the Medicare program recaptures its share of previously reimbursed depreciation paid to the provider.

Where a provider sells several assets for a lump sum amount, the regulation at 42 C.F.R. § 413.134(f)(2)(iv) requires the determination of the gain or loss (depreciation adjustment) for each depreciable asset by allocating the lump sum amount among all of the assets sold in accordance with the fair market value of each asset as it was used by the provider at the time of sale. An appropriate part of the purchase price is allocated to “all of the assets sold” regardless of whether they are depreciable (and thus Medicare-reimbursable) or non-depreciable. The allocation of the lump sum amount to non-depreciable assets results in a smaller amount being allocated to the Medicare - reimbursable assets and, thus, a higher calculated loss attributable to the depreciation adjustment. Pursuant to the consolidation transaction in the instant case, Meridian acquired the assets of the Predecessor Hospitals in exchange for the assumption of debts and liabilities. Accordingly, the Providers claimed the “purchase price” of the transaction was the total of the debts and liabilities assumed by the new entity.

In 1977, HCFA initiated a notice of proposed rulemaking for the purpose of determining whether the depreciation adjustment should be extended to “complex financial transactions” not previously addressed in subsection 42 C.F.R. § 413.134(f).⁸ In the proposed regulation, HCFA took the position that a statutory merger between unrelated parties would be treated as a sale of assets and would trigger: (1) the revaluation of assets in accordance with 42 C.F.R. § 413.134(g), and; (2) the realization of gains and losses under the provisions of 42 C.F.R. § 413.134(f). With respect to a statutory merger between related parties, or a consolidation of two or more providers resulting in the creation of a new corporate entity, the proposed rule stated that such transactions would be treated as related-party transactions and would not trigger a revaluation of assets. 42 Fed. Reg. 17485-17486 (April 1, 1977).

In the final rule published in 1979, HCFA reversed its position with respect to consolidations where two or more unrelated corporations consolidate to form a new corporation.⁹ Under the new rule set forth under 42 C.F.R. § 413.134(1)(3)(i), HCFA

⁸ See Providers’ Exhibit P-16.

⁹ See Providers’ Exhibit P-51.

resolved that “[i]f the consolidation is between two or more corporations which are unrelated . . . the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.” However, no revaluation would be allowed if related corporations consolidate. HCFA stated that the reasoning underlying this distinction was the same as the reasons for adopting a like rule with regard to statutory mergers. 44 Fed. Reg. 6912-6915 (Feb. 5, 1979).

PROVIDERS’ CONTENTIONS:

I. The Consolidation Qualifies for Revaluation Under the Regulations:

The Providers contend that the Meridian consolidation qualifies for revaluation under 42 C.F.R. § 413.134(1)(3)(i). In support of this position the Providers present the following arguments:

A. Language Addressing Consolidations in 42 C.F.R. § 413.134 is Specific, Unambiguous and Inclusive:

The regulation at 42 C.F.R. § 413.134(1)(3) defines a consolidation as, “the combination of two or more corporations resulting in the creation of a new corporate entity.” The Providers assert that the Meridian consolidation falls within the plain meaning of these words in that three independent providers each relinquished their corporate autonomy and combined to form a new entity. The provisions of 42 C.F.R. § 413.134(1)(3)(i) further direct that: “If the consolidation is between two or more corporations that are unrelated . . . the assets of the provider corporation may be revalued.” The Providers point out that they were unrelated former competitors and that their consolidation resulted from difficult negotiations and compromises. Moreover, the Intermediary acknowledged in its Supplemental Position Paper that, prior to the consolidation, the participants were autonomous and would not be considered related under Medicare regulations.¹⁰

The history of the language set forth in 42 C.F.R. § 413.134(1)(3)(i) demonstrates an evolution in the way in which Medicare compensated providers for the use of their capital assets. Until 1979, the gain/loss provisions of 42 C.F.R. § 413.134 dealt primarily with the concepts of sale or casualty. In 1977, HCFA initiated the process for determining whether or not a depreciation adjustment should be extended to “complex financial transactions” (42 Fed. Reg. 17485 (April 1, 1977)).¹¹ Under the proposed rule, Medicare took the position that a statutory merger would trigger a revaluation of the assets, but that a consolidation would be treated as a transaction between related parties and would not trigger revaluation. After subjecting the proposed rule to the rule-making process, the Medicare program reversed its position in the final rule published in 1979 stating that: “If

¹⁰ See Intermediary’s Supplemental Position Paper at p.1.

¹¹ See Providers’ Exhibit P-16.

the consolidation is between two or more corporations that are unrelated . . . the assets of the provider corporations may be revalued” (44 Fed. Reg. 6915 (Feb. 5, 1979)).¹²

The Providers point out that the Supreme Court’s first step in interpreting a statute is to look to its language, giving the words used their ordinary meaning. Comparison of the amendment initially proposed in 1977 to the language finally adopted in 1979 further supports this interpretation. It indicates that the Agency considered, initially rejected, then reconsidered and specifically included consolidations between unrelated parties as qualifying for revaluation. The added language is unqualified: it contains no wording or evidence of intent to reject, disqualify, or to delegate the power to remove from its purview, a class of consolidations that fails to meet certain conditions (written or unwritten), much less a class of providers (not-for-profit hospitals). The language added to deal specifically with consolidation offers the most direct evidence of regulatory intent.

B. Application of the Regulation Based on its Plain Meaning is Supported by the Agency’s Own Written Interpretations and Actions, and by Expert Testimony:

While the amendment including consolidations is unambiguous, the Providers note that the overall regulatory framework may have left some questions unanswered. Any lack of clarity, however, was resolved: (1) through written interpretations by Agency officials William Goeller and Charles Booth;¹³ (2) through the testimony of former Agency officials Michael Maher and Eric Yospe, and; (3) through formal Agency interpretations: e.g., Medicare Intermediary Manual (“CMS Pub. 13-4”) §4502.7. Each unambiguously supports the view that consolidations between unrelated not-for-profit, non-stock providers, such as the Providers in the instant case, trigger revaluation. The Intermediary attempted to support its theory strictly through inference; however, the Intermediary presented no Agency witness or written guidance, formal or informal, to support its interpretation. On the other hand, two government actions support the Providers’ position: (1) an initial decision by the Intermediary to compensate losses on similar New Jersey transactions (e.g., St. Barnabas Health System and St. Clares), and; (2) the prospective repeal of the regulation in 1997 because of the Agency’s concern that it had begun to generate significant Medicare losses.

C. Intermediary’s New Interpretation, Which is Based on Misinterpretation, Inference and Circular Logic, is Retroactive Rulemaking:

The Agency’s expansive interpretation of 42 C.F.R. § 413.134 - that consolidations among not-for-profits trigger revaluation - remained consistent from its passage, at least through the mid-1990s. In 1997, the Office of Inspector General (“OIG”) for DHHS issued a report indicating that gains on changes in ownership in the healthcare industry (which resulted in payments to Medicare) had turned to losses (now resulting in payments to providers). This report led to the repeal of the regulation, effective prospectively, in December, 1997. At

¹² See Providers’ Exhibit P-51.

¹³ See Providers’ Exhibits P-18 and P-24.

about the same time, the Agency began to issue a new interpretation of the regulation, and to attempt to apply it retrospectively. For example, the Agency placed much reliance on the provisions of 42 C.F.R. § 413.134(g)(4) suggesting that there must be a “bona fide sale” in order to compute a gain or loss. However, subsection (g) addresses the issue of cost basis and was intended to place a cap on the basis of assets in a rising market. The Providers insist that this regulatory provision has nothing to do with gains or losses. Moreover, the provision directly applicable to Meridian is sub-section (g)(3), Assets acquired by hospitals and SNFs on or after July 12, 1984, which the Providers satisfied. The Intermediary’s novel construction of the regulation culminated with the issuance of a Program Memorandum (HCFA Program Transmittal A-00-76), dated October 19, 2000, entitled “Clarification of the Application of the Regulations at 42 C.F.R. § 413.134(1) to Mergers and Consolidations Involving Non-Profit Providers.”¹⁴ The Providers contend that the Program Memorandum reversed a longstanding Agency interpretation, and was issued without the benefit of the rulemaking process. Rather than presenting direct evidence of regulatory intent, the Intermediary’s case is based on indirect arguments which lack regulatory or historical support and cannot be applied retroactively.

D. The Related Party Rule is Inapplicable: It Does Not Establish a Bar to Revaluation When Unrelated Providers Consolidate:

The Providers argue that the final rule set forth in 42 C.F.R. § 413.134(1)(3)(i) states that “If the consolidation is between two or more corporations that are unrelated, the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.” (emphasis added). The manual provision at CMS Pub. 13-4 § 4502.7, entitled Consolidation, makes it clear that the determination of “relatedness” is made “prior to” the consolidation. In spite of the clear instructions in the regulatory and manual provisions, HCFA advised the Intermediary in 1998 correspondence that the consolidation at issue must be considered a transaction among related parties on the basis of the membership of the boards of the new entities formed after the transaction was completed.¹⁵ Entitled “Continuity of Control,” HCFA’s new argument is clearly aimed at the issue of whether or not the consolidation qualifies for revaluation under 42 C.F.R. § 413.134. Citing the related party rules set forth in Chapter 10 of the Provider Reimbursement Manual (“CMS Pub. 15-1”) and 42 C.F.R. § 413.17, HCFA’s letter notes that the parent board of the new entity is largely composed of members of the boards of the Predecessor Hospitals. HCFA’s letter concluded that: “[B]ecause substantially the same individuals controlled the Providers both before and after the mergers . . . the related organization rules apply and revaluation should be denied.”

The Providers contend that the “Related Party Rule” was developed to deal with collusion, manipulation and like activities that are intended to produce artificial price inflation under cost based reimbursement - typically transactions with no real purpose

¹⁴ See Providers’ Exhibit P-61.

¹⁵ See Providers’ Exhibit P-6.

other than to manipulate Medicare reimbursement. “Continuity of control,” the theory put forward by HCFA and the Intermediary that involved “before and after” snapshots of the boards, is an example of corporate reorganization, a form of related party transaction where the parties are related both before and after the transaction. (CMS Pub. 13-4 § 4502.10). By contrast, a corporate consolidation involves parties that are unrelated prior to the transaction (in that the Predecessor Hospitals were competitors prior to the consolidation) and then cease to exist (CMS Pub. 13-4 § 4502.7), a point agreed upon by the Intermediary’s witness. Furthermore, the Intermediary also agreed that the Providers’ consolidation was a “bona fide transaction,” a conclusion that must be given great weight when considering the entire facts and circumstances required to make a related parties determination. The Providers also note the extensive testimony offered by their consultant and Chief Executive Officer concerning the genuine business reasons that gave rise to the transaction, and the transformation of independent, free-standing voluntary hospitals into a “healthcare system.” Finally, there is simply nothing to indicate that the trustees on the consolidated board would not act with the independence of judgment required of any individual appointed to a board, or that the circumstances create the kind of “control” that applies under the related party rule.

E. The Practical Effect of the Intermediary’s Interpretations of the Related Party Rule, and the Requirement of a Bona Fide Sale, would Disqualify Virtually All Consolidations from Revaluation, as that Term is Commonly Understood.

The Providers contend that a consolidation is not a sale. It is a fundamentally different transaction in which two or more parties create a new entity, and then cease to exist. While it is the position of the Intermediary that the presence of any members of the predecessor boards on the board of the new entity would disqualify a consolidation from revaluation, the Providers note that a consolidation is analogous to a marriage, thus, it is expected that the boards of the unrelated predecessors would contribute members to the board of the new entity. The Intermediary also argues that a consolidation must be, in reality, a different kind of transaction to qualify for revaluation (i.e., while disguised as a consolidation, it must actually be a “bona fide sale” in order to qualify). The Providers insist that the Intermediary’s interpretation would render the 1979 amendment to the regulation, in which consolidations among unrelated parties qualify for revaluation, meaningless.

F. Denying Compensation for Losses to Not-For-Profit Providers that Consolidate Makes No Sense from a Policy Perspective

The Providers believe that they have made a substantial showing that they suffered a real economic loss due to various factors including the rise of managed care, changes in technology, changes in medical practice, and cuts in government reimbursement. As a practical matter, the Intermediary’s interpretation would deny compensation to not-for-profits that often turned to consolidation to provide the framework that would enable

independent hospitals to evolve to a new corporate form, a “healthcare system,” in order to meet these new challenges. With a consolidation, compensation for losses paid to the predecessor hospitals will stay within the system (in the new entity), and will be spent on healthcare, particularly among not-for-profit providers. This may be contrasted with a “bona fide sale” where the seller is free to walk away, and spend its money on non-healthcare purposes.

Providers assert that the 1979 regulatory amendment explicitly included consolidations as a form of transaction qualifying for revaluation, and it provides no basis to create classes within a class, and to treat them differently. Nevertheless, the Intermediary argues that the particular losses at issue should be totally denied even though the regulation: (1) makes none of the subtle distinctions offered by the Intermediary; (2) sets forth no extra qualifications (i.e., a consolidation must be a sale), and; (3) furnishes no basis upon which to exclude a class of transactions or a class of providers.

II. Determination of the Amount of Gain or Loss:

In addition to the question of whether the consolidation qualifies for revaluation, the Providers believe that the adequacy of the consideration/magnitude of loss must also be addressed by the Board as part of its deliberation on the issue in dispute. The Providers contend that they have offered direct testimony and documentary evidence supporting the financial deterioration of New Jersey’s hospitals, in general, and the Predecessor Hospitals, in particular. The evidence presented was consistent with the report issued by the OIG in June, 1997,¹⁶ which noted that more than half of the hospitals that sold at a loss (53 percent) had the value of their depreciable assets drop by more than 50 percent. Moreover, the OIG report showed that 35 percent of hospitals that sold at a loss had their depreciable asset value drop by more than 70 percent. The Providers assert that, because of the factors described above and decades of rate regulation, there was little serious interest in purchasing New Jersey hospitals, and that the outstanding liabilities of the hospitals were commonly used as a yardstick for purchase prices when those transaction occurred.

The Providers contend that, if buyers had purchased the assets of the Predecessor Hospitals through a traditional sale, the assets would have been revalued without question. As the uncontroverted evidence shows, these assets were outdated, contained considerable excess capacity and required substantial new investment. Accordingly, the purchase price would have reflected this, and a loss would have been compensated under 42 C.F.R. § 413.134. However, since Meridian acquired the assets of the Predecessor Hospitals through a consolidation, the Intermediary is attempting to deny compensation altogether because the transaction was not a “bona fide sale,” and the amount of the consideration was not adequate. While the Intermediary portrays the issue as “all or nothing,” many of its arguments are related to the determination of the amount of the gain

¹⁶ See Providers’ Exhibit P-19.

or loss. This would include the methodology for the determination (sale versus an alternative, such as appraisal), or the magnitude of the amount (adequacy of consideration).

The Providers point out that, at the time of the consolidation, the Medicare regulations reimbursed providers for the consumption of capital on the basis of cost. The Agency's position over many years was that no transactions involving consolidations between unrelated parties were to be excluded from revaluation. Relying on the Agency's interpretations as set forth in the regulations, manual instruction and written correspondence, the Providers propose to allocate consideration (the assumed debt) to all of the assets in proportion to the "fair market value" of each asset (i.e., under CMS Pub.15-1 § 104.14 rather than Accounting Principles Bulletin Opinion No.16 ("APB No. 16")). Further, in response to issues raised by the Board, the Providers propose two additional adjustments: (1) Eliminate allocation of the purchase price to intangible assets, and; (2) Adjust for reduced capital payments for cost reporting periods subsequent to the transaction. The effect of these three adjustments is summarized as follows, and results in an overall claim for relief of \$33,144,858 for Medicare reimbursement purposes:

Unadjusted Loss – Based on APB No.16		\$66,683,591
Adjustment # 1 to Subtract Intangibles - Uses APB No.16 to Allocate Purchase Price	<u>\$ (6,356,749)</u>	\$60,326,842
Adjustment # 2 Uses Fair Market Value to Allocate Price Instead of APB No.16	<u>\$ (25,941,984)</u>	\$34,384,858
Adjustment # 3 – Reduced Capital Payments for Cost Reporting Periods Subsequent to the Transaction	<u>\$ (1,240,000)</u>	
Revised Loss Now Claimed by Providers		\$33,144,858
Cumulative Impact of Changes in Loss Claimed By Providers	<u>\$ (33,538,733)</u>	

In summary, the Providers contend that the consolidation that formed Meridian was between unrelated parties entitling the Providers to revaluation of their assets in accordance with 42 C.F.R. § 413.134(1). Therefore, the Board should decide that the Providers' claim for a loss on consolidation was proper, and the Intermediary should adjust the claimed amount in accordance with the Providers' above determination.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Providers in the group appeal are not entitled to Medicare reimbursement for losses allegedly incurred on the disposition of depreciable assets emanating from the consolidation transaction. The primary bases for its determination can be summarized as follows:

- The parties to the consolidation cannot show that the transaction constituted a bona fide sale.
- The Providers involved in the consolidation were related to the new entity that resulted from the consolidation.

The regulation at 42 C.F.R. § 413.134(f) provides for the recognition of a gain or loss on the disposal of assets where the disposition results from a bona fide sale. While the regulation does not define a bona fide sale, it does provide a definition of fair market value as “the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.” The sellers’ main objective is to maximize the consideration received, whereas the buyer is seeking to minimize the price paid. The Intermediary contends that the nature of the consolidation in the instant case was not intended to result in a bona fide sale between disinterested parties negotiating at arm’s length. Moreover, a review of the events and documents which led to the consolidation clearly demonstrates that the establishment of a fair market value was the furthest thing from the Providers’ collective corporate minds.

The Intermediary believes that the concept of a bona fide sale and fair market value is the bridge between a sale under 42 C.F.R. § 413.134(f) and a revaluation in a stock-like acquisition under 42 C.F.R. § 413.134(1). Accordingly, in analyzing the pre-consolidation actions of participating non-profit hospital organizations, an examination of the following questions is necessary:

- Who was bargaining on behalf of the “seller” to receive the highest price the market would bear?
- Who was separately bargaining on behalf of the “buyer” to pay the lowest price possible?
- Can the common elements of a sale be devined from the consolidation documents or actions of the participants?

The Intermediary argues that honest answers to the above questions defeat characterizing the transfer of assets and liabilities from the consolidating corporations to the new entity as a bona fide sale. The consequences associated with the execution of the consolidation is that participants suffered no compensable, measurable loss.

In support of its position, the Intermediary presents a historical analysis of the regulation at 42 C.F.R. § 413.134, and the rationale for a depreciation adjustment resulting from a

gain/loss on the disposal of depreciable assets. The point of the Intermediary's analysis is that there is nothing in the negotiation of a merger or consolidation, or the structure of such transactions, which directly or indirectly hints that the actual depreciation between the point of original acquisition and the date of merger/consolidation was materially understated based upon a market place determination of value between two parties bargaining selfishly over value. Medicare program policy shows a long controversy where control of a provider entity is acquired through a purchase of stock rather than an asset purchase. The regulatory provisions of 42 C.F.R. § 413.134(1) entitled "Transactions Involving a Provider's Capital Stock" was specifically promulgated in response to that controversy.

The Intermediary contends that the preambles to the Federal Register in both the 1977 proposed rule and the 1979 final rule clearly support its interpretation of the regulatory provisions of 42 C.F.R. § 413.134(1). The purpose of the regulation was to codify the Medicare program's position that the purchase of capital stock was not the equivalent to a purchase of assets. In a stock purchase, no revaluation of assets would be permitted and no gain or loss would be imposed on the assets owned by the corporation whose stock changed hands. The purpose of the proposed rule was to put together in one place all of the rules related to complex financial transactions involving mergers and consolidations. The Intermediary contends that the statutory merger discussion in the preamble is consistent with its argument that the key to a loss on the transferor's side is participation in a bona fide sale as the term is ordinarily understood. The gain/loss provision of 42 C.F.R. § 413.134(f) is referenced but not modified. Accordingly, if the merger is between unrelated parties, the acquired assets may be revalued by the surviving corporation and the merged corporation is entitled to a realization of gain/loss under 42 C.F.R. § 413.134(f). The Intermediary points out that it does not matter whether the surviving corporation is a provider or a non-provider. The critical element is the concept of a survivor (i.e., a buyer and seller bargained over price and value was identified). The seller accepted the price and agreed how the transaction would be structured.

In the original regulation proposed in 1977, a statutory merger between related parties was linked together with all consolidations. A line was first drawn separating mergers between related and unrelated parties. The proposed regulation reflected a conclusive presumption that a consolidation by its operation must be between related parties. However, when the final rule was published in 1979, a change was made to the prior treatment of consolidations. Instead of placing all consolidations in the related party category, a distinction was drawn between related-party consolidations and unrelated-party consolidations. While the consolidation provisions at 42 C.F.R. § 413.134(1)(3) did reference paragraph (g) of the regulation with respect to the revaluation of the assets, no back reference to the gains/losses provisions of paragraph (f) was referenced, as was done in the merger provisions of 42 C.F.R. § 413.134(1)(2).

It is the Intermediary's contention that the final regulation did not recognize a gain/loss to an entity that engages in a consolidation. In order for a loss to be considered, the loss

“trigger” in paragraph (f) must be read into subsection(1)(3) as it exists in subsection (1)(2). While it is the Providers’ position that the modification to the regulation at 42 C.F.R § 413.134(1) was designed to treat mergers and consolidations consistently, the Intermediary argues that this consistency concept requires holding a consolidating provider, as a loss claimant, to the bona fide sale standard the same as if it were a merging entity. In further support of this position, the Intermediary references the interest regulation at 42 C.F.R. § 413.153 which states that loans made to finance capital stock acquisitions, mergers or consolidations for which revaluation of assets is not allowed are considered unnecessary borrowing in the provision of patient care services. This addition to the interest regulation was part of the 1979 final rule and bolsters the Intermediary’s position that a loss is recognized only where there is a bona fide sale.

The Intermediary acknowledges that a merger or a consolidation can occur between non-profit entities. However, the Intermediary argues that a revaluation of assets and a gain/loss on disposition would be recognized only when the circumstances leading to the merger/consolidation clearly identifies the following:

- (1) One participant acting like a traditional buyer who is clearly the survivor;
- (2) The other participant/s/ acting like a seller who quietly slips away and has little or no involvement in the operation of the consolidated entity, and;
- (3) The behavior of the buyer and seller reflects traditional purchase/sale bargaining negotiations centered on price.

Since the above elements are not present in the creation of the new or consolidating entity in the instant case, the book values of the assets transferred from the Providers should be carried forward and no loss or revaluation is appropriate. Contrary to the Providers’ arguments, the motivations and actions which led to the consolidation are relevant. While the Providers believe it is only necessary to label the transaction as a consolidation between participants who were unrelated prior to closing, the Intermediary maintains that it is also necessary to focus on the actions leading to the closure to see if the characteristics of a bona fide sale existed from the outset.

With respect to the manual provision at CMS Pub. 13-4 § 4502.7, the Intermediary notes that this specific section on consolidations follows similar instructions established for asset purchases and statutory mergers (§ 4502.5 and § 4502.6, respectively). The consequences of an asset purchase set forth in § 4502.5 is non-controversial in that a gain or loss is computed for the seller. Regarding the manual provision and example presented for statutory mergers under §4502.6, an analysis of the instructions reveals that the outcome of a merger follows both the gain/loss side and the revaluation side of the depreciation regulation. The merger example in the manual provision is clearly based on the giving and receiving of real value on both sides. The example further confirms the linkage in the regulation that a bona fide sale is the trigger for a gain/loss and a revaluation in a statutory merger between unrelated parties. Since the manual provision at § 4502.7 describes a consolidation as similar to a statutory merger, it is the

Intermediary's belief that the bona fide sale requirement is indispensable. Further, the consolidation example in the manual closes with a reference to a gain/loss to the seller. Accordingly, in a consolidation, revaluation and loss recognition can only be proper when the transaction is viewed substantially similar to an asset sale or a merger under the previous manual sections.

While the Providers point out that the objective of the gain/loss provision is to produce a more accurate final determination of depreciation, the Intermediary insists that a more accurate depreciation measure is not derived from the accounting dynamics applied by the Providers in the instant case. The Intermediary contends that the pro-rata distribution of liabilities against the assets results in a complete loss of equity being allocated to all categories of assets. The resulting amount derived for depreciable assets is the product of an arbitrary calculation and its application cannot possibly "true up" depreciation. As an illustrative example, the Intermediary puts forward a hypothetical illustration of two providers, both with assets of \$10 million. However, one entity has liabilities of \$4 million and the second of \$7 million. Under the theory proffered by the Providers, the provider with liabilities of \$4 million will suffer a greater loss than the provider with \$7 million in outstanding liabilities. The Intermediary insists that there is no logical basis for the Providers' assertion that the difference between assets and liabilities measures the decline in value of the depreciable assets.

In addition to the bona fide sale argument, the Intermediary contends that there are valid related party arguments which would also preclude the allowability of the claimed loss resulting from the consolidation. It is the Intermediary's contention that the new entity is still governed by a significant number of the same personnel that governed the Predecessor Hospitals (Of the 24 members of the new corporation's board, each of the three Predecessor Hospitals appointed 8 members from their existing board). In the context of the related organization provisions at 42 C.F.R. § 413.17, Meridian obtained its facilities from the respective providers that created it. Since all of the pre-consolidation discussions and documents focused on the structure and management of the parent, the consolidation transaction should be considered among related organizations based upon a continuity of control. Moreover, it can be argued that the participants to the consolidation so inserted themselves into each other's existence through binding legal documents, that a case can be made that the participants became related to each other before the moment of consolidation.

Based on the facts and circumstances in this case, the Intermediary believes it is reasonable to conclude that the consolidation was effected among related organizations pursuant to 42 C.F.R. § 413.17 and Chapter 10 of CMS Pub. 15-1. Accordingly, the loss realized on the transfer of the depreciable assets from the non-surviving Providers may not be recognized for Medicare payment purposes in accordance with 42 C.F.R. § 413.134(1)(3)(ii).

With respect to the interrelationship of the bona fide sale argument to the related party argument, the Intermediary contends that the aspect of “bona fide” is much more than a component of the related party analysis. Even before the identity of the buyer or seller is considered, a review of the activities of the consolidating entities shows that their actions fall far short of meeting the test of a bona fide sale. Additional proof that the transaction cannot be considered a bona fide sale comes from the undisputed fact that the pre-consolidation activities of the Providers centered around the creation of an entity to acquire their assets after delicately balancing the questions of surrendering complete autonomy with the benefits of moving forward under a jointly controlled new corporate structure.

The Intermediary points out that the depreciation adjustment to the seller of assets (gain/loss) with a comparable revaluation to the buyer has been a historical part of the reimbursable depreciation determination. Intrinsic in the seller’s settlement is that the loss must arise from a bona fide sale, and that a sale between related parties would defeat the existence of a bona fide sale. However, even assuming that there is no discernable relationship between the parties, the Intermediary argues that additional analysis of the transaction is still required before an adjustment is made to the asset values. There must be entities acting like a buyer and seller who subjectively bargained over what might be fair market values under very specific facts. For the types of transactions discussed in 42 C.F.R. § 413.134(1) (i.e. straight stock purchases, mergers and consolidations) the relationship of the parties must be determined using the tools set forth in the related party regulation. In order to sustain the type of loss claimed in the instant case, the Intermediary insists that more is required than the simple fact that the parties may be found unrelated because the composition of the governing board carried forward is too small, or that the consolidating parties were unrelated during the design of the ultimate corporate “marriage” of two or more prior independent entities. The allowance of the loss is dependent upon the existence of a bona fide sale.

The Intermediary concludes that the Board’s decision must be based on the regulatory provisions of 42 C.F.R. § 413.134(1), and the interpretive preambles to that regulation in the propose rule and final rule. While the Providers believe that their position for the recognition of a loss on consolidation is supported in large part by the testimony of former HCFA officials and two sets of letters that set forth HCFA’s written interpretation of the regulation,¹⁷ the Intermediary contends that no weight should be given to either the testimony or the letters as a valid expression of program policy. The controverted letters were elicited in response to hypothetically phrased transactions involving unidentified providers, and the testimony of the witnesses provides no clear evidence that they had any role or first-hand participation in analyzing the very precise transaction being disputed in the instant case. The Board must base its decision on the regulation and interpretive preambles, and not hedged responses to hypothetical questions which do not properly apply to the consolidation transaction at issue.

¹⁷ See Providers’ Exhibits P-18 and P-24.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, parties' contentions, and evidence presented, finds and concludes that the Providers were unrelated parties as that term is defined and applied under the regulatory provisions of 42 C.F.R. § 413.17 and 42 C.F.R. § 413.134, respectively. Accordingly, a revaluation of assets and recognition of the loss incurred as a result of the consolidation is required under the specific and plain meaning of the regulation at 42 C.F.R. § 413.134(1)(3)(i).

The parties agree that the transaction at issue was a consolidation under New Jersey law, and that the regulation at 42 C.F.R. § 413.134, "Depreciation: Allowance for Depreciation Based on Asset Costs," is applicable.¹⁸ Section 413.134(1)(3) defines a consolidation as "the combination of two or more corporations resulting in the creation of a new corporate entity." The record in the instant case is undisputed that in January of 1997 Meridian was formed through the consolidation of three hospitals into one new entity, with the three pre-existing entities ceasing to exist. The transaction was motivated by economic factors affecting all of the hospitals. The hospitals concluded they could respond more efficiently to the medical community as a consolidated entity. Under the terms of the transaction, Meridian acquired all of the assets and assumed all of the liabilities associated with the operation of the Predecessor Hospitals.

The Medicare regulation at 42 C.F.R. § 413.134(1)(3) provides for the reimbursement effect of a consolidation. It states:

If at least one of the original corporations is a provider, the effect of a consolidation upon Medicare reimbursement for the provider is as follows:

- (i) Consolidation between unrelated parties. If the consolidation is between two or more corporations that are unrelated (as specified in § 413.17), the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.

- (ii) Consolidation between related parties. If the consolidation is between two or more related corporations

¹⁸ While the Board is aware that the regulation on consolidations may be interpreted as applying only to stock transactions, the Agency interprets the regulation to apply to non-profit transactions as well. HCFA's Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy, stated in a 1987 letter that the regulation applied to non-profits. See Providers' Exhibit P-24. In addition, the October 2000 "Clarification of the Application of the Regulations at 42 C.F.R. §413.134(1) to Mergers and Consolidations Involving Non-profit Providers," HCFA Program Transmittal A-00-76, states that the regulation applies to non-profits, however, it asserts that "special considerations" apply. See Providers' Exhibit P-61.

(as specified in § 413.17), no revaluation of provider assets is permitted.

The initial question to be decided by the Board is whether the consolidation was between unrelated parties. While it is undisputed that the Predecessor Hospitals were unrelated to each other prior to the consolidation, the Intermediary argues that the phrase “between related parties” requires that the consolidation transaction be examined for relationships after the transaction as well. The Intermediary refers to the related party regulation at 42 C.F.R. § 413.17 which states, in pertinent part:

(b) Definition.

- (1) Related to the provider. Related to the provider means that the provider to a significant extent is associated or affiliated with or has the control of or is controlled by the organization furnishing the services, facilities, or supplies.
- (2) Common Ownership. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.
- (3) Control. Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

Relying on subsection (3) that discusses control, the Intermediary contends that, because the board of trustees of the subsequently formed hospital system, Meridian, was composed principally of former members of the board of trustees of the individual Predecessor Hospitals, that fact creates a related party relationship that disqualifies the consolidation transaction under the applicable regulation. According to the Intermediary’s interpretation, if a consolidated corporation is substantially controlled by members of the board of the entities that formed the new corporation, there is a “continuity of control” that establishes a relationship between the consolidating corporations and the new corporation. In support of the doctrine, the Intermediary relies on the October 19, 2000 HCFA publication entitled “Clarification of the Application of the Regulations at 42 C.F.R. § 413.134(1) to Mergers and Consolidations Involving Non-profit Providers.”¹⁹ The October 2000 “Clarification” states, in part:

[W]hether the constituent corporations in a merger or consolidation are or are not related is irrelevant; rather, the focus of the inquiry should be whether significant ownership or control exists between a corporation that transfers assets and the corporation that receives them.

¹⁹ See Providers’ Exhibit P-61.

The Board finds the plain language of the consolidation regulation dispositive of the Intermediary's argument. The text at 42 C.F.R. § 413.134(1)(3)(i) specifically states "if the consolidation is between two or more corporations that are unrelated. . ." This language is crystal clear that the related party concept will be applied to the entities that are consolidating.

Until 1977, the regulation on depreciation did not specifically include consolidations, although it did cover other types of transactions. In 1977, the Secretary proposed adding a section on mergers and consolidations. The proposed section (1) to the regulation provided in relevant part:

[T]he consolidation of two or more providers resulting in the creation of a new corporate entity, is treated as a transaction between related parties (see 42 C.F.R. § 405.427). No revaluation of assets is permitted for those assets acquired by the surviving corporation...

42 Fed. Reg. 17486 (April 1, 1977)

The regulation, as finally published in 1979, abandoned the blanket rule of treating all consolidations as related party transactions and instead adopted the current version. In addition, the preface to the final rule conclusively resolves whether the language "between related parties" was intended to apply to the consolidating entities relationship with the new entity. The comment states that "assets may be revalued if two or more unrelated corporations consolidate to form a new corporation . . ." 44 Fed. Reg. 6912, 6913 (Feb. 5, 1979)

Accordingly, it is the Board's conclusion that the plain language of the regulation bars the application of the related party principle to the consolidating parties' relationship to the new entity. The evolution and construction of the regulation reflects the Secretary's deliberate rejection of the position proposed by the Intermediary and mandates a determination that only the relationship of the consolidating parties before the consolidation is relevant to whether the assets would be revalued. The Board's conclusion is further buttressed by the Agency's interpretive guidelines published in the Medicare Intermediary Manual long before the October 2000 "Clarification" cited above. CMS Pub. 13-4 § 4502.7²⁰ states, in part: "Medicare program policy permits a revaluation of assets affected by corporate consolidations between unrelated parties."

Further indication of the Agency's interpretation of the consolidation regulation can be found in the form of two letters that presented written interpretations from high level

²⁰ See Providers' Exhibit P-37.

Agency officials. In a letter dated May 11, 1987,²¹ HCFA's Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy, responded to an inquiry concerning the application of the gain and loss provisions to mergers or consolidation of not-for-profit hospitals. The conclusion of this letter was that a consolidation among not-for-profit providers gives rise to the revaluation of assets. The letter also made it clear that, notwithstanding the reference to "capital stock" in the caption of the regulation, 42 C.F.R. § 413.134(1), the Agency looked to that regulation for authority in addressing mergers and consolidations of non-stock issuing corporations because the principles involved would be the same.

The Board finds that the transaction that resulted in the formation of Meridian was a bona fide transaction under New Jersey corporation law. The completed transaction consolidated three independent hospital corporations into one new entity with the three pre-existing entities ceasing to exist. Contrary to the "continuity of control" doctrine embodied in the HCFA Program Transmittal A-00-76, dated October 29, 2000, the Board finds that such an interpretation of the related party regulation is not only inconsistent with the regulation governing consolidations, but it also flies in the face of reality with respect to corporate consolidations. The very nature of a consolidation being a combination of entities would likely result in some overlap of membership on the boards of trustees of the consolidating corporations and the new entity, as well as a continuation of other operations and personnel of the old organization. The fact that this occurs does not disqualify a consolidation from revaluation under 42 C.F.R § 413.134(1). It is implicit in the evolution of the regulation that the Secretary considered these factors but rejected them from the determination of whether a revaluation to the new entity was permissible.

With respect to the Intermediary's argument that the relationship between the Predecessor Hospitals and Meridian does not meet the traditional test of "bona fide" and "arm's length" bargaining, the Board finds that the application of such criteria also fails to consider the distinctive features of a consolidation transaction. By definition, Meridian is nothing more than a combination of the Predecessor Hospitals. That concept simply forecloses the type of bargaining between the pre and post transaction entities the Intermediary contends is necessary. Requiring "bargaining" between the old and new entity to be "arm's length" would effectively nullify the regulation's directive to permit revaluation where unrelated parties consolidate. The Intermediary's imposition of additional requirements is not supported by the plain meaning of the consolidation regulation and the Agency's own previous interpretation set forth in the manual instructions and informal written advice.

The Board acknowledges the CMS Administrator's reversal of the Board majority's decision in Cardinal Cushing Hospital/Goddard Memorial Hospital

²¹ See Providers' Exhibit P-23.

(“Cushing/Goddard”)²² involving virtually identical circumstances. Based upon his review of the related party regulations (42 C.F.R. § 413.17) and HCFA Ruling 80-4, the Administrator concluded that “the record contains compelling evidence on the relatedness of the consolidating corporations and the newly established corporation.”²³

The Board agrees that, if a consolidation is viewed only in light of the related party regulations and guidelines, a consolidation appears to be a related party transaction in that the consolidating parties create their successor and determine how it will operate, at least initially.²⁴ It is also feasible to construct an argument that the “continuity of control” concept discussed in HCFA Program Transmittal A-00-76, dated October 29, 2000, is fairly encompassed in the related party rules as they existed prior to the issuance of the Program Memorandum to Medicare Intermediaries. Whether or not the “continuity of control” is a new concept is irrelevant. Since the issue under appeal concerns the recognition of losses on the transfer of assets resulting from a consolidation, the Board cannot limit its review only to the related party rules, but it must also view the transaction in light of the specific consolidation regulations at 42 C.F.R. § 413.134(1)(3).

The Board found in Cushing/Goddard, as it does in the instant case, that the explicit language in the consolidation regulations severely limits the application of the related party regulations to consolidations. The Board also found that the related party policies, if applied as the Intermediary and Administrator assert, would emasculate the consolidation regulations. The Board finds nothing in the Administrator’s reversal of Cushing/Goddard which reconciles these competing principles. For example, the Administrator’s decision cites Internal Revenue Service (“IRS”) precedent for the proposition that a consolidation is merely a reorganization and, thus, a gain or loss is not recognized for IRS purposes.²⁵ The Administrator’s decision does not address what characteristics convert a consolidation, executed strictly according to state law and precisely fitting the regulation’s description of consolidation, into a mere reorganization. The Board observes that all consolidations and mergers are to a large extent a form of reorganization.²⁶ The Agency was undoubtedly aware of the nature of these transactions as reorganizations when the regulations and guidelines were developed. That the Agency, nevertheless, distinguished transactions that would result in a depreciation adjustment only by whether the constituent corporations were related is a fact the Board finds significant and binding.

²² Cardinal Cushing Hospital/Goddard Memorial Hospital v. Blue Cross Blue Shield Association/Associated Hospital Services of Maine, PRRB Dec. No. 2003-D6, November 27, 2002, Medicare and Medicaid Guide (CCH) ¶80,950, rev’d, CMS Administrator, January 29, 2003.

²³ Administrator’s Cushing/Goddard Decision at p.15.

²⁴ As discussed infra., the writers of the original proposed regulation took the same view but that position was reversed through the rulemaking process.

²⁵ Administrator’s Cushing/Goddard Decision at pp.12-13. The Administrator acknowledges that Medicare reimbursement rules often diverge from IRS rules and Medicare policy is not bound by IRS’ policy.

²⁶ The Administrator’s Cushing/Goddard Decision, at footnote 11 points out that Massachusetts State law recognizes mergers and consolidations as forms of reorganizations.

The Providers contend that they also qualify for Medicare reimbursement of the loss commensurate with the revaluation, claiming that it is a required second step in the process of adjusting depreciation. However, the Intermediary contends that the gain or loss recognition is not required even if revaluation is appropriate. Accordingly, the Board is confronted with two rules of construction which, in this case, will produce opposite results.

The Providers argue that a well established rule of construction applies. The consolidation regulation, subsection (1), must be viewed in the context of the entire regulation on depreciation, 42 C.F.R. § 413.134. Subsection (f), which deals with gains and losses, is also a part of the same regulation and an integral part of the greater reimbursement scheme on depreciation. It provides that “[I]f a disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider’s allowable cost.”

The Intermediary argues that its position is supported by an equally well established construction rule. The applicable regulation, 42 C.F.R. § 413.134(1), includes statutory mergers as well as consolidations. The language applicable to revaluation for both mergers and consolidations between unrelated parties is virtually identical. But, in sharp contrast to the consolidation part of the rule, the regulation on mergers goes on to provide expressly for a gain or loss to be calculated under (f). The specific inclusion of gain or loss recognition in one section, but silence in a companion section, evidences an intent not to permit recognition of the gain or loss.

Since both interpretations are plausible, the Board must look to the Agency’s interpretation of the regulation for guidance. The Agency’s guidelines specific to consolidations were published in April, 1987 in the manual instructions on Change of Ownership (“CHOW”) CMS Pub. 13-4 §§ 4500-4509. Under “General,” the Agency describes the rapidly changing healthcare delivery system over two decades resulting in restructuring of provider facilities. It states in part:

These sections present a set of working guidelines based on existing Medicare law, regulations and implementing general instructions for use by the Medicare fiscal intermediaries and by health care providers on the reimbursement implications of various types of CHOW transactions. . . .

The provisions of CMS Pub.13-4 §4502.7, entitled “Consolidation,” states “[a] consolidation is similar to a statutory merger, except that a new corporation is created during the consolidation” This section furnishes the following example and reimbursement effect:

Corporation A, the provider , and Corporation B (a-nonprovider) combine to form Corporation C, a new corporate provider entity.

By law, Corporations A and B cease to exist. Corporations A and B were unrelated parties prior to the consolidation. . . .

* * * * *

A gain or loss to the seller (Corporation A) and a revaluation of assets to the new provider (Corporation C) are computed. (emphasis added).

The Board finds this specific statement of Medicare policy to be consistent with a reasonable, albeit not exclusive, interpretation of the regulation. This formal pronouncement of the Agency was issued to the intermediaries in 1987 with the intent of providing specific guidance as to their treatment of consolidations among unrelated parties. In addition, two informal letters from high level Agency officials confirmed the Agency's view in 1987 and 1994 that recognition of a gain or loss on consolidation is required.²⁷

It is the Board's conclusion that the manual instructions, together with the history of the regulation's adoption and the Agency's consistent interpretations up until the time of the transaction at issue in this case, fully resolves the question of whether a gain or loss is to be allowed. The acceptance of the doctrine that a consolidation transaction should result in a revaluation of the assets without a depreciation adjustment (gain/loss calculation) would render the regulatory provision a nullity, and would contradict the symmetry of the regulatory scheme set forth under the Medicare program's allowance for depreciation.

While it is the Board's conclusion that the Providers qualify for a loss on disposition of assets, the Board notes that there is no clear application of this directive to consolidations in either the Medicare regulations or manual instructions. The regulation at 42 C.F.R. §413.134(1)(3)(i) instructs that the assets are to be revalued in accordance with subsection (g) entitled "Establishment of cost basis on purchase of facility as an ongoing operation." Subsection (g) does not specifically address the allocation of acquisition costs in a consolidation; however, it does address the typical bona fide sale situation. Subparagraph (3) which is pertinent to transactions after July, 1984²⁸ states the following:

(3) Assets acquired by hospitals and SNFs on or after July 8, 1984 and not subject to an enforceable agreement entered into before that date. Subject to paragraphs (b)(1)(ii)(B) through (G) and (b)(1)(iii) of this section, historical cost may not exceed the lowest of the following:

(i) The allowable acquisition cost of the asset to the owner of record as of July 18, 1984 (or, in the

²⁷ See Provider Exhibits P-18 and P-24.

²⁸ The Deficit Reduction Act of 1984 changed the reimbursement effect of some CHOW transactions effective July 18, 1984. The practical effect is that Medicare would no longer allow a "write up" from the historical cost basis of acquired assets; however, a write down" could occur.

case of an asset not in existence as of July 18, 1984, the first owner of record.):

- (ii) The acquisition cost to the new owner; or
- (iii) The fair market value of the asset on the date of acquisition.

42 C.F.R. § 413.134(g)(3).

Fair market value is defined as:

[T]he price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price is the price that bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

42 C.F.R. § 413.134 (b)(2).

Based upon its analysis of subsection (g), it is the Board's conclusion that an examination of the evidence in this case is necessary to decide the availability of an "acquisition cost" or a "fair market value" of the depreciable assets. The Providers argue that the liabilities assumed by Meridian for the Predecessor Hospitals' assets establish the consideration that is to be used as the acquisition cost. The Providers further contend that the acquisition cost resulted from arm's length bargaining among unrelated consolidating parties and, thus, it approximates the fair market value of the transaction. Accordingly, the Providers conclude that the revaluation of the assets and calculation of the loss is purely a function of allocating the consideration (liabilities assumed) among all of the assets acquired.²⁹

By contrast, the Intermediary relies on the October, 2000 "Clarification" and cites the lack of motivation to maximize the sales price of depreciable assets to support denying reimbursement of the loss claimed by the Providers. The gain/loss regulation was not amended when the additional sections on consolidation and merger were added. The old sections clearly contemplate that an "acquisition cost" will have been determined through bona fide, arm's length bargaining typical of a sale that is likely to produce fair market value.

²⁹ 42 C.F.R. § 413.134(f)(2)(iv) provides that if a provider sells more than one asset for a lump sum sale price, the gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sales price among all the assets sold, in accordance with the fair market value of each asset as it was used by the provider at the time of sale. This provision also authorizes an appraisal if there is insufficient evidence of the fair market value.

The Board acknowledges that there was no “disposition” of assets as that term is used in the regulation on gains and losses in that the Providers, though consolidated under a new corporate structure, continued to provide substantially the same services using essentially the same facilities and personnel.³⁰ However, the Board has previously concluded that the consolidation regulation, as written, insulates the application of the principles concerning “bona fide” and “arm’s length bargaining” to the relationship between the consolidating hospitals and their successor. Given the regulation’s explicit limitation on the application of the related party principle, and the Agency’s longstanding interpretation that the regulation applies to non-stock company transactions, the Board finds no authority in the regulation or the guidelines in effect at the time of the transaction to permit motivations unique to non-profits to be a determining factor in the reimbursement treatment.

Pursuant to long-standing Medicare reimbursement policy, the ultimate goal of reimbursing depreciation is to compensate the provider for the actual consumption of its assets in providing care to Medicare patients. When ownership of depreciable assets changes, consumption is measured by changes in fair market value, typically reflected in the consideration paid for those assets. Assumption of debt is a well recognized component of consideration. However, in a consolidation, the terms are dictated by operation of law and there is typically no “consideration” other than the amount of the liabilities assumed.³¹ The Providers submitted the testimony of two witnesses, ex-HCFA officials, both of whom were represented as playing an integral role in the policy development of the consolidation regulations and guidelines. Despite intensive questioning by the Board and the Intermediary, neither was able to articulate how the financing of a consolidation under the State law formula of transferring all assets and liabilities produces a better gauge of consumption of depreciable assets for Medicare services than the estimate under straight line depreciation. The Board is likewise unable to discern such rationale. Regardless of what the Agency’s rationale may have been,³²

³⁰ Lack of disposition was also a factor in the Administrator’s Cushing/Goddard Decision at p.13 – “[N]o substantial change has been affected (sic) either in the nature or substance of the taxpayer’s capital position.”

³¹ The Board notes that the greater the difference between the book value of assets and the liabilities assumed, the more difficult the application of typical allocation methodologies become. To illustrate, Corporation A and B consolidate to form Corporation C. A has been prosperous, has high utilization, good revenues, assets with a book value of \$200 million and liabilities of \$150 million. B has foundered, occupancy has dropped precipitously, it has missed debt payments and is considering closing. It has assets with a book value of \$200 million but it has liabilities of \$225 million. Applying the Provider’s Position would result (assuming 100% Medicare utilization) in Medicare paying for a higher loss on the well run, prosperous Corporation A and recouping a gain on the poor performing Corporation B.

³² Providers’ witness, formerly a HCFA official, testified that the policy brought millions of dollars in gains to Medicare up until the early 1990s when a reduction in Medicare payments and the growth in managed care made medical facilities less valuable. Although there is no independent verification in the record of gains being recaptured on consolidations, the Intermediary did not controvert the testimony.

the Board is, nevertheless, bound by the regulation's directive to adjust depreciation when unrelated Medicare providers engage in a consolidation.³³

The Board concludes that evidence of a changing healthcare environment, combined with the lack of a market for provider facilities, is persuasive that the Providers incurred a genuine economic loss of value of their depreciable assets.³⁴ That evidence also supports the Providers' position that the process of finding a suitable consolidation partner requires arm's length evaluation and bargaining similar to that in a traditional sale, although the Board believes it may be more imprecise in producing fair market value. The Medicare Intermediary Manual supports this view. CMS Pub. 13-4 § 4508.11 incorporates, as part of the Manual, Accounting Principles Board Opinion No. 16, "Business Combinations." "Medicare program policy places reliance on the generally accepted accounting principles as expressed in . . . APB No. 16 in the revaluation of assets and gain/loss computation processes for Medicare reimbursement purposes."³⁵ APB No. 16 contains a comprehensive discussion of the advantages and disadvantages and the practical difficulties of treating a combination as a purchase. Paragraph 19, entitled "A bargained transaction," states that proponents of the purchase method recognize a business combination as " . . . a significant economic event that results from bargaining between independent parties. Each party bargains on the basis of his assessment of current status and future prospects of each constituent as a separate enterprise and as a contributor to the proposed combined enterprise. The agreed terms of combination recognize primarily the bargained values and only secondarily the costs of assets and liabilities carried by the constituents . . ." Using liabilities assumed as the acquisition cost is also supported by the 1987 letter written by HCFA's Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy which stated:

In a situation where the surviving/new corporation assumes liability for outstanding debt of the merged/consolidated corporation, the assumed debt would be viewed as consideration given. Thus, in a merger or consolidation of nonstock, nonprofit corporations in which the surviving or new corporation assumes debt of the merged or consolidated corporations, the basis of the assets in the hands of the surviving or new corporation would be the lesser of the allowable acquisition cost of the assets to the owner of record as of

³³ The Board also notes the Intermediary's and Administrator's arguments that the Providers made no effort to maximize the "sales price" of the assets by offering them on the open market. The Board finds nothing in the regulations to suggest that a provider must choose a transaction form that maximizes the benefit to Medicare provided the prudent buyer concept is followed. The evidence here is that the transaction and the parties to it were chosen based on numerous permissible factors.

³⁴ In a joint stipulation dated June 28, 2002, the parties agreed that the consolidation that resulted in the formation of Meridian was largely in response to the rise in managed care, competition from other newly formed integrated delivery systems, and changes in medical practice and technology.

³⁵ The Manual cautions, though, that in certain areas, Medicare policy deviates from that in generally accepted accounting principles

July 18, 1984 (gross book value), or the acquisition cost of the assets (amount of the assumed debt) to the new owner (the surviving or new corporation). In addition, an adjustment to recognize any gain or loss to the merged/consolidated corporations would be required in accordance with regulations section 42 C.F.R. 413.134(f). For purposes of calculating the gain or loss, the amount of the assumed debt would be used as the amount received for the assets, notwithstanding any limitation on depreciable basis imposed on the surviving/new corporation.

In a letter dated August 24, 1994,³⁶ HCFA's Director, Office of Payment Policy, Bureau of Policy Development, agreed that a consolidation as defined in 42 C.F.R. § 413.134 (1)(3)(i) required a determination of a gain or loss under 42 C.F.R. § 413.134(f). With respect to the apportionment of the sale price, the letter stated the following:

Within the context of Medicare payment policy, generally accepted accounting principles (GAAP) are recognized only when a particular situation is not addressed in the regulations. Because the allocation of purchase price is addressed in both a regulation and in the instructions, GAAP (APB-16) would not apply. The regulations at 42 C.F.R. § 413.134(f)(2)(iv) and § 104.14 of the Provider Reimbursement Manual, require that when more than one asset is sold for a lump sum sales price, the gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sales price among all the assets sold in accordance with the relative fair market value of each asset. The allocation must be to all assets and must be proportionate to their relative fair market value. In the situation you described, since the sales price was a lump sum and the fair market value exceeds the sales price, the sales price must be apportioned among all the assets transferred proportionate to their relative fair market value.

The Board concludes that the assumption of liabilities through a consolidation transaction is persuasive evidence of acquisition costs. Liabilities assumed in a consolidation also may, but do not necessarily, equate to fair market value.

With respect to the determination of the gain or loss resulting from the consolidation, the Intermediary has raised questions regarding the adequacy of the consideration and has challenged the methodology for determining the amount by comparing assets to liabilities. However, since the Intermediary's position is that none of the losses claimed by the Providers should be recognized, the Intermediary's audit determinations have not addressed the methodologies associated with the calculation of the loss. Because the

³⁶ See Providers' Exhibit P-18.

Intermediary posed the issue as “all or nothing,” the Providers did not present any meaningful discussion in their briefs, exhibits or testimony about the methodology for computing a loss in the case of a consolidation. However, in the submission of their post-hearing brief, the Providers presented a matrix of modified allocation methodologies utilizing APB No. 16 and the proportionate value methodology set forth in 42 C.F.R. § 413.134(f)(2).³⁷ The effect of incorporating various adjustments to the methodologies applied resulted in a total variation in the amount of Medicare reimbursable loss of approximately \$33.5 million based on the Providers’ calculations.

In evaluating the calculation of the losses, the Board has considered various allocation methodologies, the applicable governing authorities, and the evidence presented. It is the Board’s conclusion that the acquisition cost (i.e., the amount of assumed liabilities) should be prorated using the method set forth in 42 C.F.R. § 413.134(f)(2)(iv). Since the Intermediary took the position that the Providers were not entitled to recognition of their losses, it has not analyzed the calculated losses claimed by the Providers.³⁸ Accordingly, the Board remands this matter to the Intermediary for the proper calculation of the losses pursuant to the governing regulations.

DECISION AND ORDER:

The Intermediary’s adjustments disallowing the Providers’ claimed losses on disposal of assets due to a change of ownership resulting from a consolidation were contrary to the regulatory requirements of 42 C.F.R. § 413.134(1)(3)(i) and are reversed. The matter is hereby remanded to the Intermediary for the proper calculation of the losses pursuant to the governing regulations.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, C.P.A

³⁷ Under the APB NO. 16 methodology, consideration is first allocated to monetary and current assets and then the remaining consideration is allocated to non-monetary assets. This method can result in there being little or no consideration applied to the depreciable assets that may have a substantial book value. Under the methodology prescribed in the regulation applicable to bona fide sale, consideration is allocated proportionally among all the categories of assets that are transferred. This method has its own anomaly in that in some cases it may force the allocation of inadequate consideration to liquid assets such as cash and equivalents. The proportionate value method was recognized as appropriate for consolidations by the Director of HCFA’s Office of Payment Policy in a 1994 letter. See Providers’ Exhibit P-18.

³⁸ For example, the Intermediary’s witness testified that intangibles should not be included in the allocations in this case. The Providers, in their post-hearing brief, calculated the losses using the adjustment for intangibles and proposed other adjustments that the Intermediary has not had the opportunity to verify.

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DATE: July 2, 2003

FOR THE BOARD:

Suzanne Cochran
Chairman